

# THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

34702

State File No. ....

14 OCT 20 1952

BIRTH NO. ....		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>927</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (In this place) <u>2 weeks</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural/Campbell twsp</u>		0390	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Baptist Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Route 3, Box 937, Springfield</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>MAUDE</u>		b. (Middle) <u>DAVIS</u>		c. (Last) <u>OWEN</u>	
4. DATE OF DEATH		(Month) <u>Oct</u>		(Day) <u>13</u>		(Year) <u>1952</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec 4, 1881</u>		9. AGE (In years last birthday) <u>70</u>	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Lead Hill, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Alex Davis</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Walter Owen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Walter Owen, Springfield, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Periculous Anemia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chr. Nephritis</u> DUE TO (c) <u>  </u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>  <u>1 yr.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION  <u>2900</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan.</u> , 19 <u>48</u> , to <u>10-19</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>10-17</u> , 19 <u>52</u> , and that death occurred at <u>9:10P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. J. B. Johnson</u>		23b. ADDRESS <u>1630 N. Jefferson</u>		23c. DATE SIGNED <u>10-14-52</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct 15, 1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>White Chapel Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>10-15-52</u>		REGISTRAR'S SIGNATURE <u>Edith Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Lohmeyer</u>		ADDRESS <u>Springfield, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0396

Simpson  
1630N 2nd

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Bernard F. Wright*

Licensed Embalmer No. *4293*

P. O. Address *Springfield, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.